Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ TN9502 B. WING 08/23/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 731 CASTLE HEIGHTS COURT **LEBANON HEALTH AND REHABILITATION CEI** LEBANON, TN 37087 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) N 000 Initial Comments N 000 A Licensure survey and complaint investigation (#42065) was conducted on 8/21/17 through 8/23/17, at Lebanon Health and Rehabilitation Center. No health deficiencies were cited under Chapter 1200-08-06, Standards For Nursing Homes.

Division of Health Care Facilities

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

STATE FORM

If continuation sheet 1 of 1